

# Zimbabwe

Demographic and  
Health Survey  
1988

S U M M A R Y   R E P O R T

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C. GWINDI

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The Zimbabwe DHS study is part of the worldwide Demographic and Health Surveys Program, which is designed to collect data on fertility, family planning and maternal and child health. Additional information on the Zimbabwe survey may be obtained from the Central Statistical Office, Box 8063, Causeway, Harare, Zimbabwe. Additional information about the DHS program may be obtained by writing to: DHS, Institute for Resource Development/ Macro Systems, 8850 Stanford Boulevard, Suite 4000, Columbia, MD 21045, U.S.A. (Telex 87775).

October 1990

## EXECUTIVE SUMMARY

The 1988 Zimbabwe Demographic and Health Survey (ZDHS) provides important information on health and family planning and is one of a series of surveys the Government of Zimbabwe is conducting under its National Household Survey Capability Programme.

If current fertility rates continue, women in Zimbabwe will have relatively large families — 5,5 children on average. However, the survey results indicate that women are having fewer children now than earlier in this decade when the fertility rate was 6,7 births per woman.

Most married women in Zimbabwe have used family planning at some time for birthspacing — either traditional or modern methods. Now, however, there is greater interest among women in limiting the size of their families. Between 1984 and 1988, contraceptive use among married women increased 12 percent with use of modern methods increasing even more — a 36 percent increase. Zimbabwe currently has the highest contraceptive prevalence in sub-Saharan Africa — 43 percent of married women practise family planning.



H. MUKONOWESHURO



Nearly three-quarters of these women are using the pill. This is a highly concentrated pattern of contraceptive use and Zimbabwe may want to encourage a more varied method mix among users in the future.

Two groups of women still need to be reached by the family planning programme. First, women for whom a pregnancy could pose health problems for themselves or their children need to be informed about the risks and encouraged to use family planning. Nearly 70 percent of Zimbabwean women fall into one or more of the high maternal-health-risk categories and more than half of them are not practising family planning. Second, there are many women who say they do not want a child soon or that they have completed their families but are not currently practising family planning. These women need to receive information on their family planning options.

In general, Zimbabwe has a good record in the areas of child and maternal health. The majority of children are receiving the correct immunisations and proper treatment for the common diseases of diarrhoea and respiratory infection. Most women are receiving antenatal care and trained assistance at the time of delivery.

Some children are more vulnerable than others, however. For example, rural children are almost twice as likely to die before their fifth birthdays as urban children. Moreover one in three children under age five suffers from chronic undernutrition. Children between two and three years of age are at particular risk.

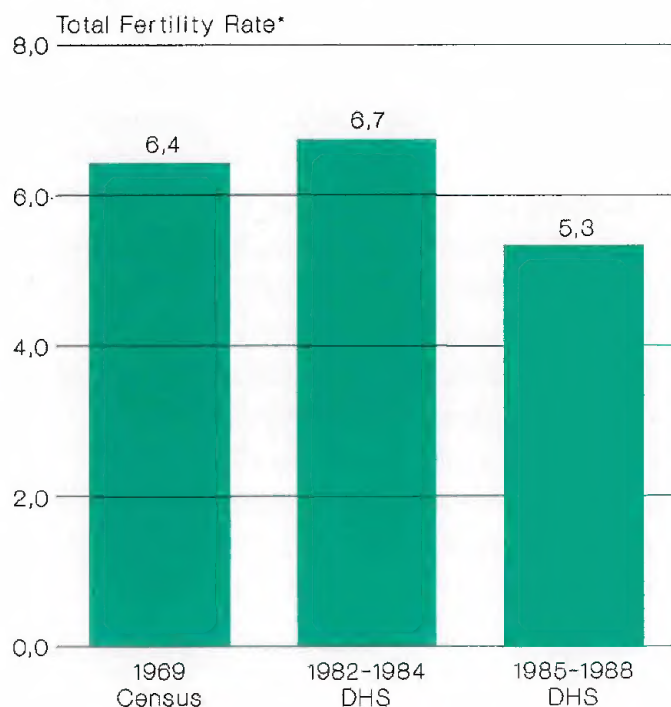
The Government of Zimbabwe has launched educational campaigns to inform people about Acquired Immune Deficiency Syndrome — AIDS. Indeed, knowledge of AIDS is widespread among Zimbabwean women — 86 percent had heard of this fatal disease. However, fewer women know how to protect themselves or take any action to do so. Future educational campaigns need to focus on these areas.

## BACKGROUND

The 1988 Zimbabwe Demographic and Health Survey (ZDHS) provides data on fertility levels, knowledge and practice of contraception, maternal/child health and knowledge about Acquired Immune Deficiency Syndrome (AIDS). The survey was conducted by the Central Statistical Office of the Government of Zimbabwe as one of the surveys under the Zimbabwe National Household Survey Capability Programme. This programme was formulated to provide a continuous and integrated data set required for adequate planning, monitoring and policy formation. The ZDHS was designed to obtain information on family planning similar to that provided by the 1984 Zimbabwe Reproductive Health Survey (ZRHS), and data on fertility and mortality which would complement information collected in the 1987 and 1988 rounds of the Intercensal Demographic Survey (ICDS).

A total of 4 201 women age 15-49 were interviewed between September 1988 and January 1989 in a national-level sample. In addition, health indicators for children under age five were collected, as well as height and weight measurements for 2 485 children age 3-60 months.

Figure 1  
TRENDS IN FERTILITY  
1969-1988\*



\*Average number of children women age 15-44 will have during their lives at fertility rates during the period.

ZDHS 1988

## FERTILITY

As in many other African countries, large families are common in Zimbabwe. On average, women say they want five children and, in fact, they will have an average of about five-and-a-half children if fertility rates continue at current levels.

However, the ZDHS data indicate that today Zimbabwean women both want and are having smaller

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*Women in Zimbabwe are having an average of about five children each.*

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families than they did in the past. A comparison of the current situation with those of women who have essentially completed their childbearing years highlights this change. Women age 40-49 have had an average of 6.6 births, about one birth more than women are having at current rates. Much of this change has occurred very recently. Average fertility for the period 1982-1984 was 6.7 births per woman, and the rate for the 1985-1988 period was 5.3 births per woman — nearly a 21 percent decline (see Figure 1). It should be noted that these figures do not appear to be consistent with results of the 1982 Census, which recorded a fertility rate of 5.4 children per woman, and further analysis is required to obtain firm data.

## Factors Affecting Fertility

Socio-economic factors such as education and residence affect fertility indirectly while demographic factors — contraceptive use, breastfeeding and age at marriage — exert direct influence. The ZDHS provides data for both.

### *Education and Residence*

At current fertility rates, women who have attended secondary school are having significantly fewer children than women with no education: 3,8 as compared to 7,0 children. This relationship suggests that fertility is likely to decline further in Zimbabwe because more and more young women are attaining at least some secondary education. In addition, the recent

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*Women who have attended secondary school are having three fewer children, on average, than women with no education.*

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fertility declines have been more pronounced among educated women.

Fertility levels also vary significantly depending on whether a woman lives in an urban or a rural area. About one-third of the women surveyed live in urban areas and they are having an average of slightly less than four births. In contrast, rural women are having slightly more than six births each. The recent trend toward lower fertility is also pronounced among urban women. Their fertility has declined more than 28 percent over the 1982-1988 period while the fertility of rural women dropped about 17 percent.

## *Marriage Patterns*

Almost all Zimbabwean women eventually marry. Marriage occurs at a fairly young age, although not as young as in many other African countries. More than half of all Zimbabwean women had married for the first time before age 20. Only three percent married for the first time later than age 24. However, the ZDHS results do indicate that younger women are delaying marriage slightly. Among women age 25-29 years at the time of the survey, the median age of first marriage is about 19 years. Among women age 20-24, it is about 20 years. A decline in fertility is often associated with increases in the average age of first marriage.





MINISTRY OF INFORMATION

Although marriage usually marks the beginning of sexual activity for women, the ZDHS results indicate that a significant proportion of young adult women become sexually active before marriage. One in six never-married teenagers has had sexual relations at some time and one in two never-married women age 20-24 has been sexually active. Health workers are concerned about sexual activity among unmarried women, particularly teenagers. Unplanned pregnancies to teenage women pose risks for the health of both the mother and the baby. In addition, an unplanned pregnancy may limit the educational attainment of young adult mothers.

#### *Breastfeeding and Postpartum Infecundity*

Breastfeeding can prolong the natural period of infecundity following childbirth and thus protect the mother from pregnancy. Breastfeeding is also a significant safeguard against infant mortality. The practice of breastfeeding is nearly universal among Zimbabwean women. Over 80 percent of babies are still being breastfed a year after birth, and half continue to be breastfed for 18 months. Because of these breastfeeding patterns, women in Zimbabwe are, on the

average, protected from pregnancy for about a year after the birth of a child. Younger women, women living in urban areas and more educated women tend to breastfeed for shorter periods and thus are at risk of another pregnancy somewhat sooner.

## Family Planning

Family planning practices also directly affect fertility. Zimbabwean couples have long relied on traditional methods and are increasingly using modern contraceptive methods.

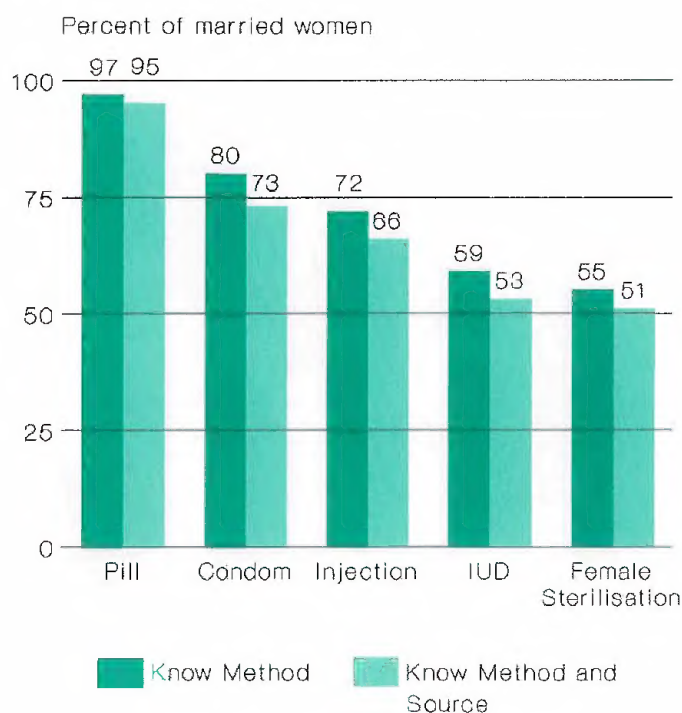
The government of Zimbabwe supports an active family planning programme, through the Zimbabwe National Family Planning Council (ZNFPC) and other governmental and private organizations. The sections below highlight the successful outcomes of these activities and suggest areas which may need more attention in the future.

### Knowledge of Contraception

Nearly all married women (99 percent) know of at least one contraceptive method. The pill is the most widely recognized modern method: 97 percent of married women know it as a way of spacing or limiting births. Other commonly recognized methods include condom, injection, IUD and female sterilisation (see Figure 2).

Almost all married women could also identify a source of family planning services (96 percent). For most methods, the majority of women name

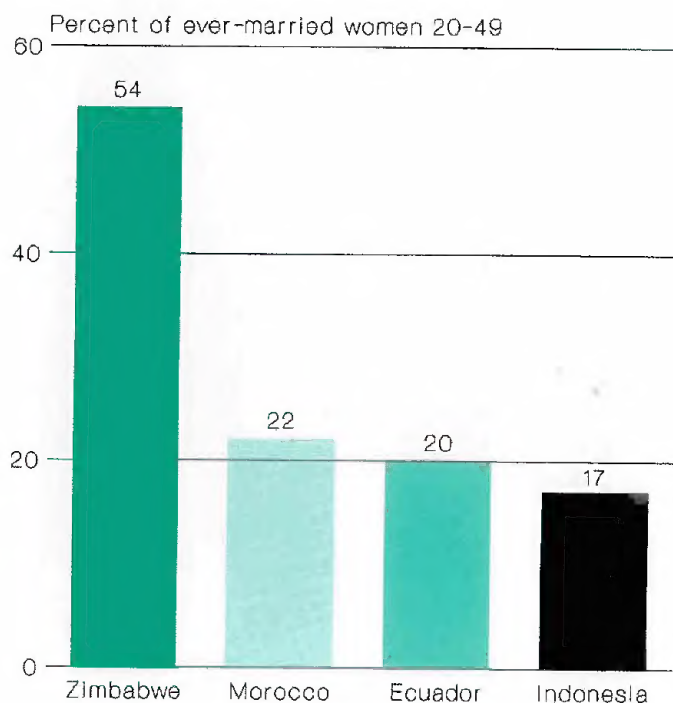
*Figure 2*  
**KNOWLEDGE OF FAMILY PLANNING METHODS AND SOURCES**  
(Currently married women 15-49)



ZDHS 1988



*Figure 3*  
**USE OF FAMILY PLANNING BEFORE  
 THE BIRTH OF A SECOND CHILD**



ZDHS 1988

government-sponsored clinical facilities run by the ZNFPC, the Ministry of Health (MOH) and local governments as the sources from which they would obtain the method. The importance of the ZNFPC outreach programme is evident as its community-based distribution (CBD) workers are mentioned by one in four women as the source from which they would get the pill.

#### *Use of Family Planning*

Use of family planning is not new in Zimbabwe. Nearly eight out of every ten married women have, at one time or another, used a method of family planning. Furthermore, women are more likely to have used a modern method — primarily the pill — than a traditional method. Sixty-three percent of married women have at some time employed a modern method and 48 percent have relied on a traditional method, primarily withdrawal.

Nearly half of ever-married women began using family planning before they had two children. Younger women are slightly more likely to have initiated family planning this soon but even among women age 40 and older, one-third followed the pattern. The desire to space births appears to have been the primary motivation for young women with few children to adopt family planning. This is an unusual pattern compared to that common in Asia, the Near East and Latin America, where the movement toward the adoption of family planning more often began with older women with many children (see Figure 3).

Currently 43 percent of married women are using a method; 36 percent have chosen a modern method

and 7 percent use a traditional one (see Figure 4). This level of contraceptive prevalence is the highest known in sub-Saharan Africa.

As expected, use of family planning varies by residence and education. Nearly 52 percent of urban

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*Forty-three percent of married women in Zimbabwe practise family planning, the highest rate known in sub-Saharan Africa.*

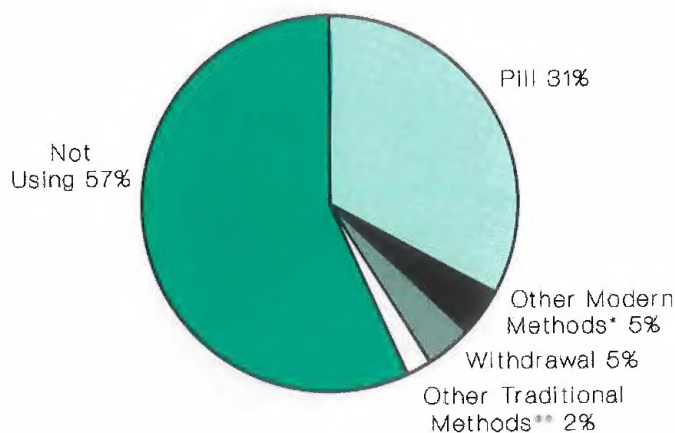
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women practise family planning while about 40 percent of rural women do so. Women with at least a secondary education are also more likely to practise family planning than women with no education — 56 percent compared to 32 percent — and more than twice as likely to use a modern method.

A comparison of the findings from the ZDHS with the 1984 Zimbabwe Reproductive Health Survey (ZRHS) indicates that the use of any family planning method among married women increased by 12 percent during that brief period. More importantly, current users are more likely to be relying on modern methods

Figure 4

**CURRENT USE OF FAMILY PLANNING**  
(Currently married women 15-49)

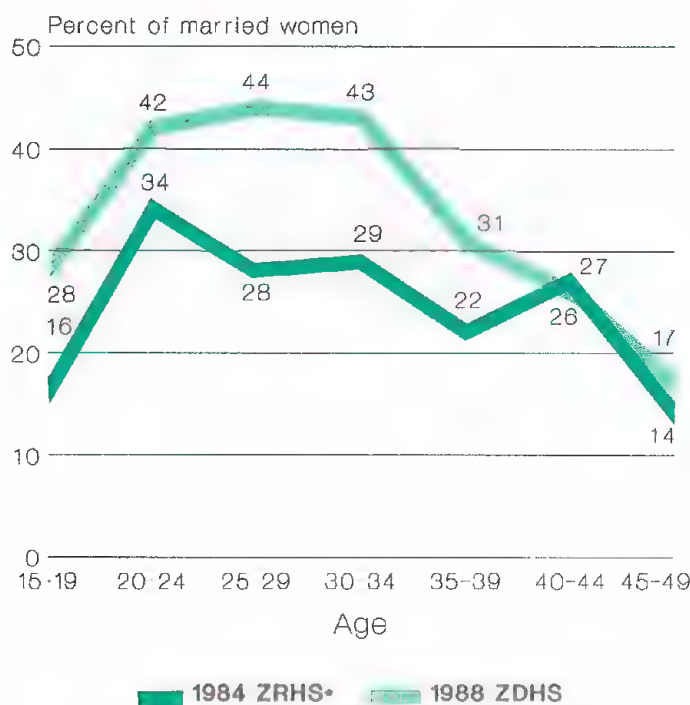


\* Includes: sterilisation, condom, injection, IUD and vaginal methods

\*\* Includes: periodio abstinence, other

ZDHS 1988

**Figure 5**  
**TRENDS IN USE OF MODERN**  
**CONTRACEPTION BY AGE**  
**1984 AND 1988**  
*(Percent of married women using a modern method of*  
*contraception at time of survey)*



\*Zimbabwe Reproductive  
and Health Survey

ZDHS 1988

than users in 1984. The use of modern methods has increased by 36 percent, with a particularly large increase among women age 25-34 (see Figure 5). This switch toward the use of more effective methods along with increasing educational levels for women and urbanization is likely to lead to lower fertility in the future.

#### *Potential Need for Family Planning Services*

Despite this impressive record, the Zimbabwe family planning programme continues to face challenges in assisting couples to achieve their reproductive goals.

Of the 43 percent of married women practising family planning, nearly three-quarters use the pill. Withdrawal is the second most commonly used method. All of the other methods — female and male sterilisation, IUD, injection, condom, barrier methods and other traditional methods — account for only 16 percent of total family planning use. The dominance of the pill in the method mix is an element of programmatic concern. Worldwide research has shown that programmes which offer a variety of methods attract and retain more family planning users.

In addition to the women already practising family planning, 34 percent of married women may be in need of family planning services. These women either do not



want any more children (18%) or wish to delay their next birth by two or more years (17%) but are not currently using contraception (see Figure 6). More than half of these women say they intend to practise family planning in the future and thus provide a natural audience for family planning outreach activities.

These married non-users who want to avoid or delay pregnancy identified some of the reasons they are

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*One-third of married women are estimated to be in need of family planning services, but only half of them intend to use contraception in the future.*

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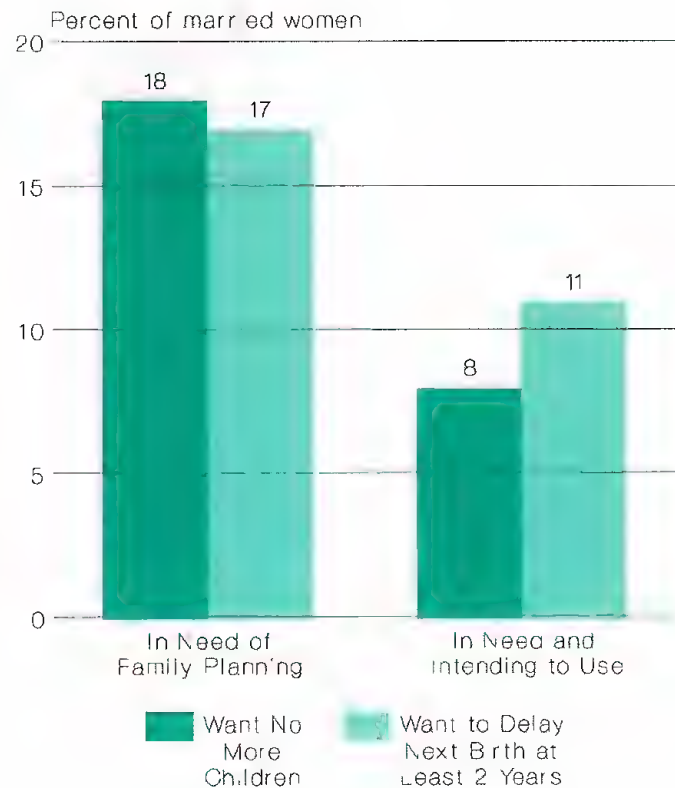
not using family planning. About 19 percent mention infrequent sex as their main reason for not using family planning. Another 9 percent of non-users believe their husbands disapprove of family planning and 5 percent disapprove themselves. For 6 percent lack of knowledge is a barrier to use. Education programmes for both men and women can help address these concerns.

Another key issue is availability: 18 percent of those at risk of an unintended pregnancy say they lack access to family planning methods; another 13 percent find methods inconvenient to use. A smaller percentage of women cite health concerns or cost as obstacles to use. The programme could attract more clients by expanding both access to services and the range of methods offered, accompanied by information on the risks and benefits of all available methods.

Figure 6

### ESTIMATED NEED FOR FAMILY PLANNING SERVICES

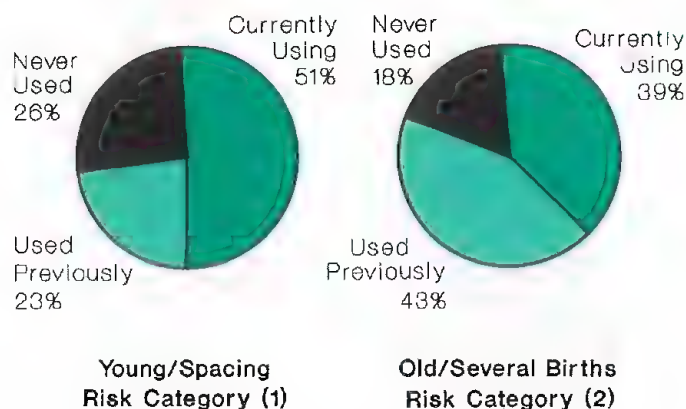
(Married women 15-49, not currently using family planning, but wanting to delay or prevent another pregnancy)



ZDHS 1988

Figure 7

### CONTRACEPTIVE USE STATUS AMONG MARRIED WOMEN IN HIGH HEALTH RISK CATEGORIES



(1) Includes women age 18 and under or age 19-34 and less than 15 months postpartum

(2) Includes women age 35 and over or with 5 or more births

ZDHS 1988

Of particular concern are women who would be at risk of maternal illness or death if they became pregnant but who are not using any method of family planning. The categories of increased risk of maternal problems include: pregnancies before age 18, pregnancies less than two years apart, pregnancies after five previous births and pregnancies after age 35.

*Many women at risk of an unintended pregnancy cite lack of access to services and inconvenience as reasons for not using family planning.*

Overall, 70 percent of married Zimbabwean women fall into one or more of these high-risk categories.

However, many of these women are practising family planning: 51 percent of married women who are either younger than 18 or have recently had a birth, and 39 percent of older women or those with several children (see Figure 7). Non-users in these groups need to be identified and provided with information about the health risks they face and the appropriate family planning methods available to them.

## HEALTH

The ZDHS collected information relating to three issues of importance to policy-makers and programme administrators: child health, maternal health and knowledge about Acquired Immune Deficiency Syndrome (AIDS). There are about two million children under age five and more than two million women of reproductive age in the country. These two groups are at particular risk of illness and death which could be prevented with proper care. AIDS is, tragically, a growing problem around the world. Currently, prevention is the only hope for limiting the disease's spread. The ZDHS data can help Zimbabwe plan effective information campaigns aimed at prevention.

**Child Health and Survival**

ZDHS data estimate that 57 out of every 1 000 babies born during the ten years before the survey died



K. KAMASHU

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*One in ten rural children  
dies before reaching his or her  
fifth birthday.*

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before their first birthdays and 87 died before their fifth birthdays. The infant mortality rate of 57 compares favourably with the all-Africa average of 109 deaths per 1 000 births\* but is considerably higher than the rate in developed countries.

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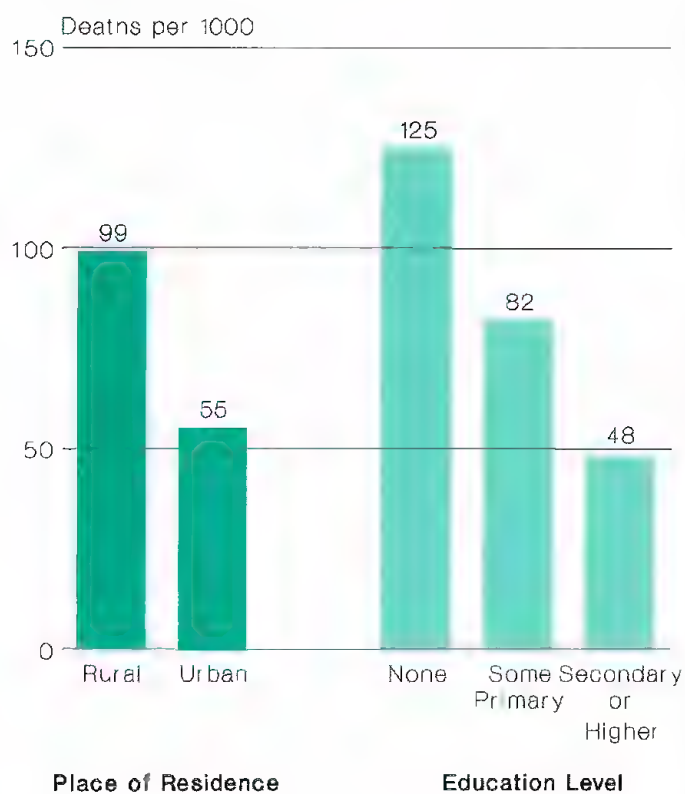
\*Population Reference Bureau, 1990 World Population Data Sheet.



### Factors Affecting Child Survival

- A number of factors influence child survival:
- **Place of Residence** Both infant and under-age-five mortality levels are higher in rural areas. Rural children are almost twice as likely to die before their fifth birthdays as urban children (see Figure 8).
  - **Mother's Education** Children whose mothers have no education are more likely to die before their fifth birthdays than those born to women who have attended secondary school (see Figure 8). The difference is particularly noticeable among children age 1-4 — they are six times more likely to die.
  - **Mother's Age at Birth** Children born to mothers who are younger than age 20 or older than age 39 are more likely to die than children whose mothers are age 20-39.
  - **Birthspacing** Babies born less than two years after a previous birth face higher mortality risks: they are nearly twice as likely to die before their fifth birthdays as babies born two or more years after a sibling (see Figure 9).

Figure 8  
**CHILD MORTALITY\* BY RESIDENCE  
AND EDUCATION OF MOTHER**  
1978-1988



\* Deaths to children under age 5

### *Prevention of Childhood Diseases*

Zimbabwe's Expanded Programme of Immunisation (ZEPI), established in 1982, aims to protect children against six major childhood diseases — tuberculosis, diphtheria, whooping cough, tetanus, poliomyelitis and measles. Ninety-six percent of

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*Most children have received vaccinations to protect them against the major childhood diseases.*

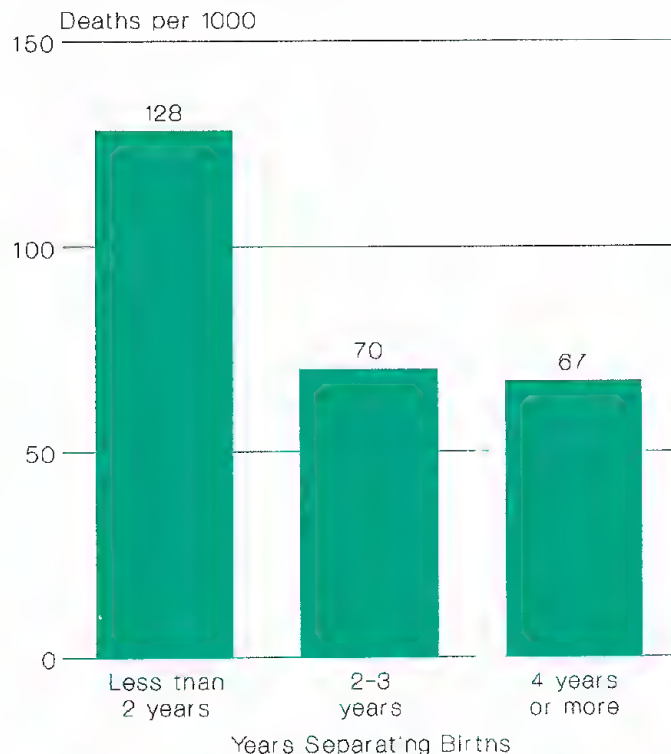
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children age 12-23 months are reported to have received at least one immunisation. About three-quarters of these children have health cards documenting their immunisations and 86 percent of children with health cards have received all the required immunisations.

### *Diarrhoea and Acute Respiratory Infection*

Diarrhoea, often a leading cause of childhood mortality, occurs frequently among children under age five in Zimbabwe. Mothers reported that one in 11 children had diarrhoea in the 24 hours preceding the survey, and one child in five had had it during the previous two weeks. The proportions of children with diarrhoea were slightly higher in rural than in urban areas.

Figure 9  
**CHILD MORTALITY\* AND BIRTHSPACING 1978-1988**



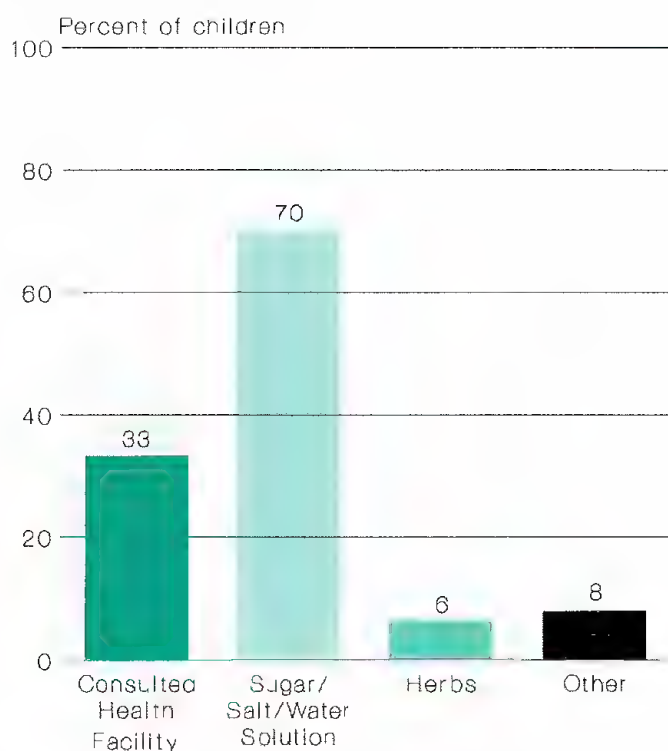
\* Deaths to children under age 5

ZDHS 1988

Figure 10

**TREATMENT OF DIARRHOEA\***

(Among children under age 5 with diarrhoea in the 2 weeks before the survey)



\*Percentages total more than 100% due to multiple responses

ZDHS 1988

The vast majority of children with diarrhoea received treatment (see Figure 10). Seventy percent received a recommended home solution made from sugar, salt and water, an effective and inexpensive treatment for the dehydration which is often the cause of death among children with diarrhoea.

Respiratory infection is also very common among Zimbabwean children. Forty-six percent had a cough at some point during the four weeks prior to the survey. Again, in the majority of cases, children with a cough received some treatment. Over half were taken to a health facility, one in four children received an injection, a similar proportion was given oral antibiotics and nearly two-thirds were given cough medicine.

#### *Nutritional Status of Children*

As part of the ZDHS, children age 3-60 months were weighed and measured to assess their nutritional status. The study found that 29 percent of these children were short in relation to their age, compared with an international reference population. This finding suggests that chronic undernutrition is a serious problem.

Chronic undernutrition is twice as common among children age 1-3 years as among infants less than one



year old, probably due to the nutritional benefits of breastfeeding. The prevalence of chronic undernutrition is also associated with the length of the birth interval: one in three children born less than two years after a previous birth is undernourished, compared with one in four children born after an

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*Almost 30 percent of children age 3-60 months show signs of chronic undernutrition.*

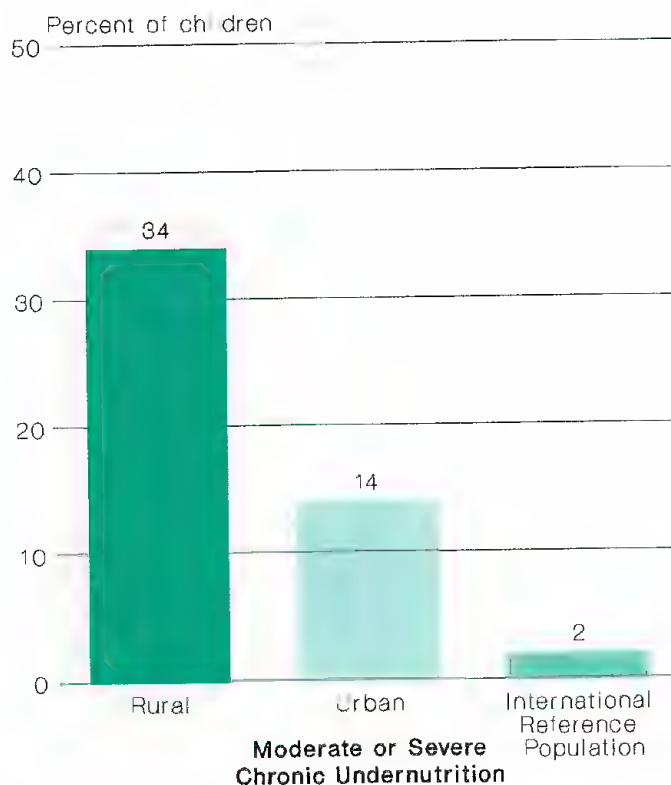
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interval of two years or more. In addition rural children and children of mothers with no education are more than twice as likely to be undernourished as urban children and children with educated mothers (see Figure 11).

### Maternal Health

Proper antenatal care can reduce the risk of maternal illness or death during pregnancy, labour and delivery, and is associated with lower infant mortality rates. For 91 percent of births in the five years prior to the survey, mothers had at least one antenatal-care visit with trained medical personnel (doctor or trained nurse) during their pregnancies. In addition, 70 percent of the deliveries during the same time period were attended by trained personnel, primarily nurses. A trained attendant was present during 90 percent of urban deliveries, compared with only 62 percent of rural deliveries. Despite these rural-urban differences, the data show that women in Zimbabwe do seek maternal health care.

Figure 11  
**CHRONIC UNDERNUTRITION**  
(Percent of children age 3-60 months who are short for their age)\*



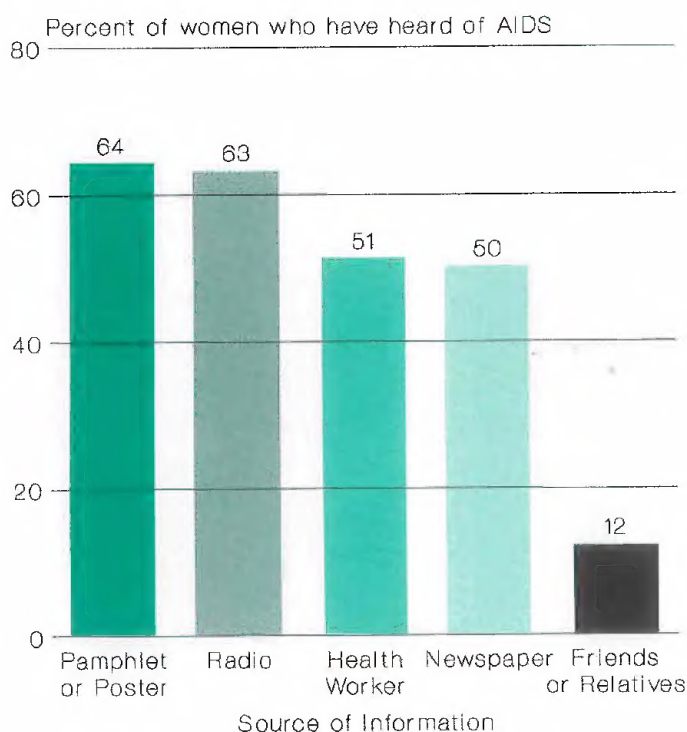
\*Two or more standard-deviations below the median of the international reference population

ZDHS 1988

Figure 12

**AIDS INFORMATION**

(Among women having heard of AIDS, percent receiving AIDS information, by source)



ZDHS 1988

**AIDS Awareness**

Zimbabwe has an active programme to disseminate information about AIDS. The ZDHS provided an opportunity to assess the effectiveness of this information campaign.

In general, awareness of AIDS is widespread among women in Zimbabwe: 86 percent report having heard of AIDS. Of these, 64 percent had received

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*Awareness of AIDS  
is widespread, yet few women  
take action to  
protect themselves.*

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information about AIDS from a pamphlet or poster, 63 percent from the radio, 51 percent from a health worker and 50 percent from the newspaper (see Figure 12). Those least likely to have any knowledge of the disease are those with no education, those in polygamous unions, rural women and those in the oldest age groups.

Of those who had heard of AIDS, 80 percent were able to report at least one way they thought the disease spreads: 75 percent named at least one correct way and 50 percent named only correct modes of transmission. The majority of women knew that AIDS is sexually transmitted and mentioned that having sex with more than one partner is risky.

Most sexually active women have not taken any steps to avoid getting the disease. About one-third of these women believe they are not at risk of the disease. Among other frequently given reasons for taking no action are: 1) the respondent believes that AIDS cannot be avoided and 2) the respondent did not know how to avoid the disease. These responses indicate that more accurate information about AIDS prevention and self-protection is needed.

## CONCLUSIONS

Zimbabwe has made great progress in providing family planning services throughout the country. It has the highest contraceptive prevalence in sub-Saharan Africa — 43 percent among married women, three-quarters of whom use the pill. Recently, contraceptive use in general has increased and use of modern methods has increased at an even faster rate.

Women have traditionally used some form of family planning for birthspacing in Zimbabwe. Over the past few years, however, more women are expressing an interest in using family planning to limit the size of their families. Women are still having relatively large families — 5.5 children on average — but this represents more than one child fewer than they were having just a few years ago.

Two groups of women may have special need of effective family planning methods: (1) women in high-risk categories for whom a pregnancy could be detrimental to their or their infants' health, and (2) women who do not want a child soon or any additional children but who are not currently practising family planning. As reproductive goals change, including a growing interest in limiting births, the family planning programme will be challenged to provide a greater variety of contraceptive methods and to inform women about the methods most appropriate to their needs.

In general, Zimbabwe has a good record in the areas of infant and maternal health. Most children are receiving the correct immunisations and are treated for the common diseases of diarrhoea and respiratory

infection. Almost all women receive antenatal care and the majority are assisted at the time of delivery by trained personnel. One area of concern is the finding that 30 percent of children age 3-60 months suffer from chronic undernutrition.

AIDS is a growing concern. Knowledge of AIDS is widespread among Zimbabwean women. However, few women know how to protect themselves or take any action to do so. Future educational campaigns need to focus on these areas.



UNICEF/CAROLYN WATSON



## FACT SHEET

*Statistical Yearbook of Zimbabwe, 1987; Provincial Population Data Sheets, 1989*

*Central Statistical Office*

Population size (millions, 1982) _____	7,6
Population growth rate (percent, 1982) _____	3,0
Population doubling time (years) _____	23
Crude birth rate (births per 1000 population, 1982) _____	40
Crude death rate (deaths per 1000 population, 1982) _____	11

### *Zimbabwe Demographic and Health Survey 1988*

#### **Sample Population**

Women age 15-49 _____	4 201
Children age 3-60 months (based on mother's interview) _____	2 485

#### **Background Characteristics of Women Interviewed**

Percent urban _____	33,5
Percent with no education _____	13,5
Percent with some primary education _____	55,9
Percent with secondary education or more _____	30,6

#### **Marriage and Other Fertility Determinants**

Percent women currently married _____	62,9
Percent of women age 25-49 never married by age 25 _____	3,2
Median age at first marriage for women age 25-49 _____	18,6
Median length of breastfeeding (in months) <sup>1</sup> _____	19,3
Median length of postpartum amenorrhoea (in months) <sup>1</sup> _____	12,6
Median length of postpartum abstinence (in months) <sup>1</sup> _____	4,3

#### **Fertility**

Total fertility rate (projected completed family size) <sup>2</sup> _____	5,5
Mean number of children ever born to women age 40-44 _____	6,6
Percent of women currently pregnant _____	8,9

#### **Desire for Children**

Percent of currently married women:	
Wanting no more children (including sterilised women) _____	32,7
Wanting to delay next birth at least 2 years _____	35,3
Mean ideal number of children for women age 15-49 _____	4,9

#### **Knowledge and Use of Family Planning**

Percent of currently married women:	
Knowing any method _____	98,7
Knowing any modern method _____	97,8
Knowing any traditional method _____	86,8
Ever using any method _____	79,0
Ever using any modern method _____	63,0
Ever using any traditional method _____	48,1

Currently using any method _____	43,1
Currently using any modern method _____	36,1
Pill _____	31,0
IUD _____	1,1
Injection _____	0,3
Condom _____	1,2
Sterilisation _____	
Female _____	2,3
Male _____	0,2
Currently using any traditional method _____	7,0
Periodic abstinence _____	0,3
Withdrawal _____	5,1
Folk methods _____	1,5

#### **Health**

Infant mortality rate <sup>3</sup> _____	57,4
Under five mortality rate <sup>4</sup> _____	86,9
Percent of births for which the mothers: <sup>5</sup>	
Received antenatal care during pregnancy from a doctor or trained nurse _____	91,3
Received at least one anti-tetanus injection during pregnancy _____	78,7
Were assisted at delivery by doctor or trained nurse _____	69,6
Percent of children age 0-2 months breastfed _____	95,0
Percent of children age 10-11 months breastfed _____	89,8
Percent of children age 18-19 months breastfed _____	52,1
Percent of children age 12-23 months:	
Having received at least one vaccination, according to health card and/or mother's report _____	96,2
With a health card _____	77,6
Vaccinated, among children with a health card, against:	
BCG _____	97,7
DPT (series of 3 doses) _____	92,4
Polio (series of 3 doses) _____	92,2
Measles _____	92,8
All 6 diseases _____	85,9
Percent of children under five years of age with diarrhoea <sup>6</sup> _____	19,7
Percent of children under five years of age having diarrhoea who were treated with salt, sugar, water solution _____	70,0
Percent of children under five years of age with cough <sup>7</sup> _____	46,6
Percent of children under five years of age with cough who were taken to a health facility _____	55,1
Percent of children age 3-60 months considered chronically undernourished, based on height-for-age _____	29,0
Percent of women who had heard of AIDS _____	85,9

<sup>1</sup> Median duration (the point at which half are above and half are below), based on births during the 36 months preceding the survey

<sup>2</sup> Based on births to women age 15-44, during the period 0-4 years before the survey

<sup>3</sup> Deaths to infants under age one, per 1000 live births, rates are for the ten-year period preceding the survey (approximately 1978-88)

<sup>4</sup> Deaths to children under age five, per 1000 live births; rates are for the ten-year period preceding the survey (approximately 1978-88)

<sup>5</sup> Based on births occurring during the five years before the survey

<sup>6</sup> Based on children under age five reported by the mothers as having diarrhoea during the two weeks before the survey

<sup>7</sup> Based on children under age five reported by the mothers as having a cough during the four weeks before the survey

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